The True Forces Behind Magnetism

CNA/NNOC's position statement on hospital magnet status

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BACKGROUND

In 1990 the American Nurses Association (ANA) approved a proposal that recognized excellence in nursing services. This was based on earlier research done by the American Academy of Nursing on practice in U.S. hospitals. The variables used in the study were called "forces of magnetism" and the facilities were called "magnets" because they allegedly attracted and retained registered nurses.

The Magnet Recognition Program was developed by the American Nurses credentialing Center (ANCC), an ANA subsidiary, to recognize "healthcare organizations that provide nursing excellence." The program also provides a vehicle for "successful" nursing practices and strategies.

The Magnet program is based on quality indicators and standards as defined in the ANA Scope and Standards for Nurse Administrators (2004). The Magnet designation process includes fourteen (14) qualitative factors in nursing also known as the 14 "forces of magnetism" which was first identified through the research done in 1983 (See Appendix A). The stated intent is also to provide "consumers with the ultimate benchmark to measure the quality of care that they can expect to receive."

HISTORY OF MAGNET HOSPITAL RECOGNITION

The Beginning – "Forces of Magnetism" Aligned with Patient Interests

The Magnet hospital program began in the early 1980s when healthcare provider services were funded by fee-for-service and indemnity insurance methods of paying and guaranteeing payment for healthcare services. Hospital and medical group revenue and profit were generated by providing services to meet patient needs as determined necessary by physicians and other professional caregivers including direct-care registered nurses. Fee-for-service financing of hospital care delivery generally aligned the interests of physician and hospital providers with patients in ways that promoted trust, continuity, and financial incentives to provide necessary care for patients.

In this economic scheme, the original magnet hospitals were recognized on the basis of superior RN staffing ratios and significant administrative support for direct-care RNs. The staffing ratios and administrative support provided the necessary foundation for effective, RN-friendly scheduling policies and a direct-care RN-patient relationship which allowed competent practice under professional standards of care. As described by the American Academy of Nursing in 1983:

> In magnet hospitals there is a low patient-to-registered nurse ratio, with adequate staff to provide total nursing care to all patients. Furthermore, the quality and complexity of patient care needs are taken into consideration when the staffing is planned; this is important in minimizing stress. The nurse does not feel overworked and has an opportunity to meet all of the patient's needs — psychological, interpersonal, and physical. There is also time for interaction among nurses so that continuity of care is insured and nurse-to-nurse consultation is encouraged. The nurses express great satisfaction in their opportunity to provide good care and in administration's support for it.

The 1983 study by the AAN interviewed nurses working for hospitals that were part of the original selection process for identifying magnet hospitals who summarized their experiences by identifying "*the most important*" factors "*in promoting recruitment and retention of staff.*" The key factor and driving force for all factors was "*a nurse-patient ratio which assures quality patient care,*" followed by "*flexible staffing to support patient care needs,*" "*flexible scheduling,*" and the practice of "*primary nursing.*" Staffing ratios was the absolute and mandatory condition of magnet hospital nursing service that enabled nurses to care for their patients in a manner consistent with their professional practice obligations, ethical norms, and personal career mission as registered nurses. The AAN summarized the essential finding of its study in unequivocal terms: "*The nurses speak of being able to deliver safe, adequate care as a result of these staffing patterns.*"

Sharing similar operational interests driven by fee-for-service economic incentives, nursing and hospital management at the original magnet hospitals broadly agreed with nurses regarding the central factors that had an impact on recruitment and retention, citing: "*adequate staffing and flexible scheduling,*" "*good salaries and benefits,*" "*participative management with active involvement of staff in planning and decision making,*" "*primary nursing,*" and "*a predominantly RN staff that is fully supported by nursing administration.*" Nursing executives emphasized the importance of RNs being able to carry out skilled nursing tasks themselves, without delegation to less trained individuals. And the original magnet hospitals were founded on a commitment to maintaining a sufficient complement of direct-care RN staff to meet patient needs at all times, with virtually no use of agency personnel.

This was the meaning and workplace reality of the "forces of magnetism" identified by the American Academy of Nursing 25 years ago, a time when institutional providers and physician groups were generally thriving in a dominant "fee-for-service" market characterized by a close alignment of provider, direct-care nurse and patient interests, and institutional economic incentives to ensure safe, competent, and therapeutic nursing care.

Managed Care Financing of Health Care Services—Forces of Magnetism Abandon Patients

Managed care capitation financing arrangements have become the dominant means for funding hospital and physician services. HMO/insurers provide a share of the monthly premium dollar for a negotiated split between medical and hospital provider organizations, transferring to physicians and hospitals the insurance risk of incurring costs for providing patient care services in excess of premium revenue from a group (and corresponding opportunity to gain surplus revenue) by limiting services to assure premium revenue exceeds costs. This radical change in hospital economics imposes operational mandates which determine the nature and methods of delivery of hospital patient care. The revenue generation priority of capitation-financed hospital service creates an inherent, adversarial relationship between patients and institutional providers operating under financial incentives to limit hospital access, ignore individual patient needs, deny necessary services, and disregard minimum standards of safe, therapeutic, and competent nursing care. The financial imperatives require massive cutbacks in nursing budgets and a concomitant reduction in direct-care RN staff and administrative support that were the fundamental perquisites to magnet hospital recognition as originally conceived and undertaken.

Managed care economics motivated a significant restructuring and downsizing of hospital nursing services and decimated the ranks of hospital direct-care registered nurses. At the same time, managed care-imposed barriers to hospital access produced an inpatient population that is far sicker and more medically fragile than ever before, requiring more intense, experienced, and specialized direct registered nursing care. Managed care strategies to increase revenue generation by downsizing the direct-care registered nurse workforce and restructured patient care methods also set in motion a continuing deterioration of working and practice conditions which accelerated registered nurse flight from hospital direct patient care positions and effectively discouraged new registered nurse interest in hospital direct-care positions. Hospital direct-care registered nursing practice today is severely burdened by excessive patient assignment loads, mandatory extended work hours, unsafe patient handling practices, and routine exposure to risks of professional license, discipline, and/or malpractice liability inherent in the working and practice conditions created and maintained in derogation of prevailing community standards of hospital and professional registered nursing care.

The new Magnet recognition program is bound by the economic imperatives and operational incentives of a method of healthcare

service financing which transfers to healthcare providers the insurance risk of incurring costs for providing patient care in excess of premium revenue from participating groups. The essential hospital market conditions which were prerequisite for achieving a "nursing environment" eligible for magnet recognition no longer exist and cannot be replicated on an institutional basis.

Shared Governance – Compromising RN Duty of Loyalty to Patient Interests

The new ANCC core criteria for magnet hospital accreditation reflect a significant emphasis on staff nurse decision making and influence over the delivery of patient care.

While labels differ, the evidence is conclusive that a Shared Governance model is a key component in structuring professional nursing practice to achieve magnet recognition. Virtually all the hospitals that achieve "magnet status" use a "shared governance" structural model for sustaining professional nursing practice.

The ANCC magnet accreditation process begins with a potential applicant's "Organization Self-Assessment for Magnet Readiness" according to a detailed set of standards and inquiries. A threshold condition to demonstrate "readiness" for magnet status consideration standards is: **there must be *"congruence between the mission, vision, values, philosophy, and strategic plan of the nursing department and those aspects of the organization."*** (ANCC, Organization Self-Assessment for Magnet Readiness)

The Shared Governance imperative of "congruent interests" requires staff nurse loyalty to the operational priorities of commercial healthcare institutions. RN professional licensure responsibilities and ethical duties require exclusive loyalty to patient interests. Magnet/Shared Governance "enterprise loyalty" is antithetical to the direct-care RN fiduciary duty to provide care in the exclusive interests of patients.

The structural imperatives of magnet hospital governance over nursing services cannot be harmonized with nor incorporated into collective bargaining representation. Nursing shared governance is a managerial innovation that legitimizes nurses' control over practice, while extending their influence into administrative areas previously controlled only by managers. Proponents of magnet recognition view union representation of nurses as a barrier to successful shared governance because "union restrictions may prohibit management from implementing the shared governance model." More importantly, participation in magnet-acceptable shared governance procedures and committees requires staff nurses to assume expressly stated managerial and supervisory responsibilities and authority. Such participation provides presumptive evidence of exclusion from labor law rights to organize for collective bargaining.

Today's Magnet Hospital Imperatives are in Fundamental and Irreconcilable Conflict with the Interests and RN Duty of Loyalty to Patients

The economic incentives of institutional providers and the commercial mandates of the healthcare industry conflict with the interests, health, and safety of patients and professional and ethical responsibilities of direct-care RNs.

Today's ANCC Magnet Status Recognition certification program and its various components, including Shared Governance, are the direct and exclusive creation of the commercial priorities and economic incentives of corporate healthcare.

The stated "goals and objectives" are deceptive and are mere deceptions for the fundamental commercial priorities of the program. Neither these priorities nor the economic interests of the healthcare industry as presently constituted can be reconciled with the interests of patients or rights and obligations of direct-care registered nurses.

Moreover, any concession to Magnet Status Recognition/Shared Governance and similar schemes provides continuing cover for an ill-conceived healthcare system and significant obstruction to winning single-payer healthcare reform.

Consistent with the essential purposes of CNA/NNOC as the voice for direct-care RNs and the Code of Professional RN Practice adopted in the CNA/NNOC Bylaws, the position of CNA/NNOC must be unqualified opposition to Magnet Status Recognition and similar programs, including categorical rejection of any form of participation or support for such programs and their deceptive entrapments like Shared Governance. The responsibility of patient advocacy and affirmative obligations of collective patient advocacy offer no opportunity for such concession.

STANDARDS FOR EVALUATING WHETHER ANCC "MAGNET HOSPITAL" DESIGNATION IS IN THE INTERESTS OF DIRECT-CARE RNS AND THEIR PATIENTS

CNA/NNOC Code of RN Professional Responsibility

The CNA/NNOC Bylaws Code of RN Practice include the following standards:

1. The nurse assumes responsibility and accountability for competent and appropriate performance of the RN Duty of Patient Advoca-

The 14 "Forces of Magnetism"

Force 1: Quality of Nursing Leadership
Force 2: Organizational Structure
Force 3: Management Style
Force 4: Personnel Policies and Programs
Force 5: Professional Models of Care
Force 6: Quality of Care
Force 7: Quality Improvement
Force 8: Consultation and Resources
Force 9: Autonomy
Force 10: Community and the Healthcare Organization
Force 11: Nurses as Teachers
Force 12: Image of Nursing
Force 13: Interdisciplinary Relationships
Force 14: Professional Development

cy, acting in the exclusive interests of the patient, as the patient's advocate, by initiating action to improve healthcare or to change decisions or activities which are against the interests or wishes of the patient, as circumstances may require, and by disclosing information and providing patient education as necessary for informed patient decisions about healthcare before care is provided to the patient.

2. The nurse recognizes the importance of collective patient advocacy to the public health and the integrity of professional nursing standards of care, and participates in necessary and appropriate actions and exercises of collective patient advocacy to protect the public health and safe patient care standards against erosion, restructuring, degradation, deregulation, and abolition by the large healthcare corporations, hospital chains, HMOs, insurance companies, pharmaceutical corporations, and other powerful economic institutions and interests which today seek to control the availability, access, and quality of healthcare services for purposes of profit and surplus revenue generation against the interest of patients and healthcare consumers.

"Participation in magnet-acceptable shared governance procedures and committees requires staff nurses to assume expressly stated managerial and supervisory responsibilities and authority. Such participation provides presumptive evidence of exclusion from labor law rights to organize for collective bargaining."

Independent Professional Responsibility to Act in the Exclusive Interests of Patients – Direct-Care RN Fiduciary Duty to Patients

State nursing practice acts and registered nursing boards implementing regulations, practice standards, and professional license guidelines generally impose a "fiduciary responsibility" on registered nurses who accept assignment to a direct-care RN-to-patient relationship in which nursing care is provided. The fiduciary obligation is to provide care in the exclusive interests of the patient without compromise or surrender to other interests, including the commercial, operational, revenue generation, or budgetary interests of health facility employers, physician practice groups, healthcare systems, managed care organizations, or health insurers/HMOs.

The fiduciary relationship and related professional fiduciary duties of direct-care registered nurses to assigned patients are fundamental public health and safety regulations created to protect patient safety.

Necessary Conditions for Safe, Competent, and Therapeutic Registered Nursing Practice in the Interests of Patients

Protection of working and practice conditions for direct-care RNs that are essential for safe, competent, and therapeutic nursing care:

(1) An RN-to-patient relationship which allows for competent performance of all aspects of the nursing process, enforced by objective minimum standards for safe patient care (i.e., numeric unit-based RN-to-patient staffing ratios);

(2) The right and practical ability to exercise independent professional responsibility and judgment to determine and implement nursing care in the exclusive interests of patients, uncompromised by and without interference arising from the conflicting commercial and revenue generation interests and demands of the healthcare industry.

Magnet Recognition and Replacement Technology

To achieve and maintain a "Magnet" designation status, hospitals are required to demonstrate it has a mechanism in place which collects and analyzes patient outcome data with input from the nursing staff while incorporating clinical decision-making technologies.

Hospitals seeking such designation have deployed these clinical technologies, which incorporate Computerized Physician Order Entry (CPOE) systems, computerized charting programs, including computerized medication charting, and decision-support technology which is based on rigid standardization of the decision-making process of the direct-care RN.

RNs have a unique patient advocacy role in the healthcare delivery system, and technology can only be used to augment this unique role. In analyzing the safe, therapeutic and effective values of any technology, RNs must be able to explore the potential of technology replacing human interaction in the delivery of patient care and the supplanting of critical thinking and independent clinical judgment with rigid clinical pathways or RN displacement and/or override technologies.

Technology-driven care depersonalizes the RN relationship with her/his patients. Unfettered use of technology will have a chilling effect on the RN's ability to advocate in the exclusive interest of her/his patient. Undue reliance on technology can jeopardize the accuracy of diagnosis and treatment of patients.

Such reliance will also create erosion of skills for the next generation of RNs who (unless stopped) will be trained in tasks instead of educated in skills. It has the potential of destroying the art and science of professional registered nurses.

Human cognition is still superior to so-called "machine intelligence." One fact is certain: computers and machines are only good for storing information. They cannot think, analyze, or reason as registered nurses do, nor are they educated or capable of critical thinking or have the ability to make split-second judgments in crisis intervention situations. Computers and machines are capable of quantifying data but it will take a qualified RN to synthesize and interpret the data – otherwise it is meaningless.

In order to be competitive in a market-driven healthcare system, "Magnet" recognition schemes have endorsed these skill-degrading, RN replacement, obliteration of individual advocacy, and union avoidance clinical technologies.

THE HEALTHCARE REALITY AND CONTEXT OF MAGNET HOSPITAL RECOGNITION

In response to the imperatives of capitation financing and consolidation of the hospital and health insurance industries over the past two decades, aided significantly by federal policies supporting economic concentration in HMO and provider markets, the hospital industry abandoned safe, therapeutic, and competent nursing care as an operational priority and restructured hospital nursing services to accommodate predominantly revenue generation purposes.

Key elements of this restructuring of hospital nursing care are a substantial cause of the current shortage of hospital direct-care registered nurses, including the following:

(a) mass layoffs and permanent reductions in forces of hospital direct-care registered nurses beginning in the early 1990s;

(b) work "redesign" measures to fragment and deskill hospital

registered nursing practice in order to transfer registered nurse functions to unlicensed personnel and other non-RN caregivers;

(c) elimination of the direct-care registered nurse assessment-controlled, transparent, and verifiable patient acuity system methodologies for determining registered nurse staffing levels based on individual patient needs;

(d) implementation of new, "proprietary" patient classification systems for determining nurse staffing levels and "skill mix" which purport to rely on registered nurse assessment of patient needs, but conceal methodologies and determinative functions from staff nurses and government licensing authorities, that are incapable of scientific verification and validation, and routinely produce outcomes forecasting nurse staffing levels which objectively serve revenue generation targets and bear no relation to registered nurse patient assessments; and

(e) introduction of new technologies which override the independent professional clinical judgment of direct-care registered nurses.

The healthcare industry's restructuring and downsizing of hospital nursing services decimated the ranks of hospital direct-care registered nurses. At the same time, managed care-imposed barriers to hospital access produced an inpatient population that is far sicker and more medically fragile than ever before, requiring more intense, experienced, and specialized direct registered nursing care.

Managed care strategies to increase revenue generation by downsizing the direct-care registered nurse workforce and restructured patient care methods also set in motion a continuing deterioration of working and practice conditions which have accelerated registered nurse flight from hospital direct patient care positions and effectively discouraged new registered nurse interest in hospital direct-care positions.

Hospital direct-care registered nursing practice today is severely burdened by excessive patient assignment loads, mandatory extended work hours, unsafe patient handling practices, and routine exposure to risks of professional license, discipline, and/or malpractice liability inherent in working and practice conditions created and maintained in derogation of prevailing community standards of hospital and professional registered nursing care.

ESSENTIAL ELEMENTS OF THE MAGNET RECOGNITION PROGRAM

- strategic avoidance of hospital direct-care nursing regulation;
- application of "evidence-based" deceptions to hospital nursing service patient care/practice standards;
- rip-off of high public trust in nurses (to provide care in the exclusive interests of patients) to cover commercially-motivated, deceptive redesign of direct-care practice standards intended to restrain independent judgment and action by direct-care RNs, obstruct patient advocacy, and subvert the direct-care nursing process with the mandate to serve commercial interests over patient interests;
- marketing gimmicks to promote false appearances of superior hospital nursing practices and quality patient outcomes (the "gold standard");
- strategies to gain market advantage for public and private reimbursement for hospital nursing services;
- and most importantly, a strategy to compromise the direct-care RN duty of exclusive loyalty to patients by making commercial enterprise loyalty to hospital employers a condition of RN employment for the purpose of eliminating a significant barrier to unchecked profiteering on individual and family healthcare risk as presented by an independent direct-care RN voice, professional responsibility, and duty patient advocacy in the exclusive interests of patients.

Conclusion: The conflicts between commercial and revenue generation interests and patient interests cannot be reconciled by marketing gimmicks and workplace deceptions. Direct-care RN participation in schemes to conceal this reality and enable industry priorities is a fundamental conflict of interest and repudiation of professional ethics.

CNA/NNOC POSITION

Oppose any and all accreditation or recognition (including "Magnet" designation) schemes that;

Directly, or indirectly interfere or compromise direct-care RN professional responsibilities to provide care in the exclusive interests of patients and take all necessary and appropriate actions to ensure patient safety, even if such actions conflict with employer interests, policies, or orders.

Establish or permit sanction or recognition of different standards of nursing service or patient care performance which allow for recognition of substandard or different classes of competent care in derogation of the universal health principle of one standard of care.

Purport to replace or, in effect, operate to replace governmental regulation of hospital services for the public health and safety.

Directly or indirectly coerce, intimidate, induce, or encourage frontline caregivers to accept assignments, duties, or responsibilities which require enterprise loyalty and/or apparent assumption of managerial or supervisory authority that would disqualify them for collective bargaining representation.

Apply TQM/Shared Governance schemes for the strategic purpose and effect of individual and collective patient advocacy suppression and union avoidance.

Deploy technologies to override the independent professional judgment of the RN and restrict the RN duty and right to advocate; that are skill degrading; and are purposely developed to maintain a healthcare industry driven by private interest rather than the individual healthcare needs of the patient.

Fail to establish and promote safe staffing standards based on individual patient acuity of which objective, unit-specific hospital RN-to-patient staffing standards are the minimum.

Fail to establish or allow for an objective, transparent process for determining and establishing direct-care RN control over working and practice conditions demonstrated to improve the quality of the RN-patient therapeutic relationship, reduce errors and adverse outcomes, and improve recruiting and retention.

Deceive and confuse direct-care RNs with TQM/Shared Governance schemes, including pay-for-performance incentives; to engage, support, and suppress direct-care resistance to benchmarking schemes that redefine disease, treatment, and outcomes; as well as cutbacks in safe, therapeutic, and competent direct-care nursing service, reductions in staff, and nursing service budgets; priority of surplus revenue generation and other anti-patient practices under the deceptive cover of "gold standard" redesign of patient/nursing care standards.

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Continuing Education Test

Public Health and Retail Clinics

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TEST QUESTIONS

1 CNA/NNOC opposes any and all accreditation or recognition (including "Magnet" designation) schemes that deceive and confuse direct-care RNs with Shared Governance schemes, including pay-for-performance incentives, and priority of surplus revenue generation practices under the deceptive cover of "gold standard" redesign of traditional patient/nursing care standards.

❑ True ❑ False

2 In analyzing the safe, therapeutic, and effective values of any technology, registered nurses must explore the potential of technology replacing human interaction in the delivery of nursing care.

❑ True ❑ False

3 Magnet designation fails to establish and promote safe staffing standards based on individual patient acuity, of which objective, unit-specific RN-to-patient ratios are the minimum.

❑ True ❑ False

4 Magnet designation is an excellent alternative to local, state, and federal governmental regulation of hospital services for public health and safety.

❑ True ❑ False

5 Magnet designation status hospitals improve patient care by collecting and analyzing patient outcome data with input from the nursing staff while incorporating clinical decision-making technologies.

❑ True ❑ False

6 Magnet hospitals improve wages, pensions, and other economic benefits for recruitment and retention of RNs.

❑ True ❑ False

7 Registered nurses must take all necessary and appropriate actions to ensure patient safety even if such actions conflict with employer interests, policies, or orders.

❑ True ❑ False

8 The CNA/NNOC position is to oppose any and all accreditation (including "Magnet" designation) that purports to replace or, in effect, operate to replace governmental regulation of hospital services for public health and safety.

❑ True ❑ False

9 The Magnet Recognition Program promotes superior hospital nursing practices and quality patient outcomes. Shared Governance empowers nurses to achieve this goal.

❑ True ❑ False

10 Undue reliance on technology will create erosion of skills for the next generation of RNs who (unless stopped) will be trained in tasks instead of educated in skills. It has the potential of destroying the art and science of professional registered nursing.

❑ True ❑ False

Name: _____

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